



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

February 18, 2010

Tom Whittemore
Communicare, Inc #5 Kuna
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #5 Kuna, provider #13G021

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #5 Kuna, which was conducted on February 11, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 2, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by March 2, 2010. If a request for informal dispute resolution is received after March 2, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Barbara Dern, QMRP Common abbreviations/symbols used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional IPP - Individualized Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified PRN - As Needed QMRP - Qualified Mental Retardation Professional	W 000		<div style="text-align: center;"> RECEIVED MAR 12 2010 FACILITY STANDARDS </div>	
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all information was kept confidential for 8 of 8 individuals (Individuals #1 - #8) whose full names were noted to be posed in the main living area of the facility. This resulted in individuals' information being available to other individuals, visitors, and non-staff. The findings include: 1. Observations were conducted at the facility on 2/8/10 from 4:20 - 5:10 p.m. and 6:10 - 7:15 p.m., and on 2/9/10 from 7:10 - 8:45 a.m. During those times, the following information was noted to be	W 112	W112 Corrective Actions & System Changes: We are aware of this and are supportive of this expectation and have information in our Policy and Procedure Manual addressing confidentiality. However, in reviewing this policy the issue of posting identifying information was not addressed in writing. We have therefore adjusted this policy and will send out policy clarification to all CCI locations with the expectation that QMRPs will review this information at the next scheduled staff meeting at each location. Identifying Others Potentially Affected: System Changes: All individuals at this location were affected.	4-1-10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

3-10-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 112	Continued From page 1 posted in the main living area of the facility: - A list with the full names of Individuals #1 - #8 was observed to be posted to the right of a storage cabinet. Beside each individuals' name was the color of their assigned exercise mat. - A list with the full names of Individuals #1 - #8 was observed to be posted to the left of the desk. Under each individuals' name was a list of the individuals' parents, family members, and guardians, along with their telephone numbers. During an interview on 2/11/10 from 11:45 a.m. - 1:40 p.m., the AQMRP stated the main living area of the facility was accessed by individuals' family and friends, as well as service people and maintenance people who were not direct employees of the facility. The AQMRP stated the posted information should have been moved to a confidential location. The facility failed to ensure individuals' full names and personal information was maintained in a confidential manner.	W 112	Monitoring: As part of the monthly maintenance checklist, Assistant QMRPs (House Managers) will now be expected to review all postings at assigned locations. This report is sent to the Administrator for review.		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination of service objectives for 4 of 4 individuals (Individuals #1 - #4) reviewed. That failure	W 159	<u>W159</u> Corrective Actions & System Changes: We have written service objectives in the same format for many years without content problems being cited. In doing an analysis of this citation, we feel there are 1) some examples which we do have data collection systems for which were not fully explained at the time of the survey; 2) some examples which were technical oversights on our part; and 3) some examples where corrective action is indicated.	4-11-10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 159	<p>Continued From page 2</p> <p>resulted in individuals' service objectives not being monitored to ensure their needs were being met. The findings include:</p> <p>1. Individual #2's 6/18/09 IPP stated she was a 41 year old female whose diagnoses included severe mental retardation and spastic dysplasia (a form of cerebral palsy). Her IPP documented service objectives which included the following:</p> <ul style="list-style-type: none"> - Have her fall prevention plan followed to reduce falls. - Have assistance with toileting hygiene. - Have adaptive equipment available and maintained in good repair. - Have her headaches monitored. <p>However, the record did not contain methods for monitoring or documenting the implementation rates and effectiveness of the service objectives.</p> <p>2. Individual #3's 6/10/09 IPP stated she was a 40 year old female whose diagnoses included moderate mental retardation and third nerve palsy (disorder involving eye movement). Her IPP documented service objectives which included the following:</p> <ul style="list-style-type: none"> - Have her fall prevention plan followed to assist in transfers and reduce falls. - Be assisted to participate in oral motor exercises. - Have adaptive equipment available and maintained in good repair. - Participate in physical activities using her walker, playing catch, and pedaling. <p>However, the record did not contain methods for monitoring or documenting the implementation</p>	W 159	<p><u>Fall Prevention Plans</u></p> <p>We are confused about the intent of these examples. We do have a comprehensive system for tracking and trying to reduce falls and Fall Prevention Plans are a reference tool for this system. We track all falls by recording these in the Medical Observation Log, completing an Accident/Injury report, and having staff report these to both the Administrator/Designee and a nurse.</p> <p>The QMRP has a tracking system for problem solving (see attached for each example cited) and all falls are recorded on our Tracking/Trending form (see attached for each example cited) and these are reviewed at scheduled Trending/Tracking meetings. We expect staff to refer to Fall Prevention Plans as a reference and, as such, do not have a tracking system that indicates daily implementation. We believe the corrective action for these examples is to change our service objective to "Track and review all Falls" for "each occurrence"</p> <p><u>Adaptive Equipment</u></p> <p>Seven of eight individuals at this location use wheelchairs for mobility. We have implemented a wheelchair and adaptive equipment check and response system but are having both internal and external issues with this</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 159	<p>Continued From page 3</p> <p>rates and effectiveness of the service objectives.</p> <p>3. Individual #4's 6/10/09 IPP stated she was a 42 year old female whose diagnoses included severe mental retardation and scoliosis. Her IPP documented service objectives which included the following:</p> <ul style="list-style-type: none"> - Be assisted to follow steps of a fall prevention plan to reduce risks of injury. - Participate in sensory stimulus to reduce target behaviors. - Be assisted with toileting and after toileting hygiene activities. - Have adaptive equipment available and maintained in good repair. <p>However, the record did not contain methods for monitoring or documenting the implementation rates and effectiveness of the service objectives.</p> <p>4. Individual #1's 6/18/09 IPP stated she was a 46 year old female whose diagnoses included profound mental retardation and spastic quadriplegia (a form of cerebral palsy affecting all four limbs and trunk). Her IPP documented service objectives which included the following:</p> <ul style="list-style-type: none"> - Have her fall prevention plan followed to reduce falls and assist with transfers. - Have adaptive equipment available and maintained in good repair. - Be assisted to go to the bathroom every 2 hours. <p>However, the record did not contain methods for monitoring or documenting the implementation rates and effectiveness of the service objectives.</p>	W 159	<p>system. To ensure internal implementation, check of this system has been added to the monthly preventative maintenance checklist and the QMRP is now assigned to review this system. We have less control over external systems. The only wheelchair maintenance service now requires preauthorization before they will do any repair and this is a time consuming process. In addition, repairs and ordering of parts often takes long periods of time. The Administrator and/or RN Supervisor will continue to work with this provider in an attempt to resolve these issues and the AQMRP has been instructed to document all these issues. We will adjust our service objective to "Repair adaptive equipment" "as needed".</p> <p><u>Other Issues/System In Place</u> Monitoring of Headaches: we don't understand why this was an example as we track headaches both through medical observation logs (see attached) and on the Trending/Tracking form (see attached).</p> <p><u>Other Issues/Change Indicated</u> Participate in physical activities using walker, playing catch, and pedaling: we agree that this objective is confusing and it will be re-written into two objectives with associated data collection systems in place. Participate in sensory stimulus to reduce target behavior: this is a replication of a data based program</p>		

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

3-10-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 312	<p>Continued From page 5</p> <p>NOS, and bipolar disorder. Her Physician's Order Sheet and Progress Notes documented the following:</p> <ul style="list-style-type: none"> - 7/6/09: Valium (an anxiolytic drug) 15 mg was prescribed one hour prior to a dental appointment. - 7/25/09: Valium 15 mg was prescribed one hour prior to a dental appointment. - 9/4/09: Diazepam (Valium) 15 mg was prescribed prior to a gynecological appointment. - 1/12/10: Diazepam 15 mg was prescribed one hour prior to a dental appointment. <p>However, Individual #4's Psychoactive Medication Reduction Plan, dated 9/28/09, did not include the use of Valium for dental and medical appointments.</p> <p>When asked during an interview on 2/11/10 from 1:15 - 1:40 p.m., the QMRP stated a plan for the use of Valium had not been developed.</p> <p>The facility failed to ensure Individual #4's use of Valium for dental and medical appointments was incorporated into a plan.</p>	W 312	<p>Identifying Others Potentially Affected: System Changes: All individuals at this location are potentially affected and all orders for these types of PRN medications will be reviewed and added if not already included.</p> <p>Monitoring: The QMRP Supervisor prepared this information so the initial oversight was her responsibility. The QMRP did not catch the oversight when reviewing and filing the document. The Quality Assurance Process which would have caught this oversight was scheduled to occur in February. Each will redo their part of the process until corrections are insured.</p>		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure adequate general and preventative medical care was provided to 1 of 3 individuals (Individual #3) reviewed, who had a diagnosed of</p>	W 322	<p><u>W322</u></p> <p>Corrective Actions & System Changes: The protocol for use of the Vagus Nerve Stimulator will be re-written by the RN Supervisor and staff inserviced by nursing staff.</p> <p>Identifying Others Potentially Affected: System Changes: This is the only individual at this location who uses this equipment.</p>		4-11-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	<p>Continued From page 6</p> <p>seizure disorder. This resulted in the potential for an individual's health needs to not be met. The findings include:</p> <p>1. Individual #3's 6/10/09 IPP stated she was a 40 year old female whose diagnoses included moderate mental retardation and seizure disorder.</p> <p>An observation was conducted at the facility on 2/8/10 from 4:20 - 5:10 p.m. At 4:50 p.m., Individual #3's entire body was noted to start shaking. A staff member immediately went to Individual #3, took a magnet from the right back side of her wheelchair, and swiped the magnet across the upper left side of Individual #3's chest. The staff stated Individual #3 was having a seizure.</p> <p>During record review, on 2/10/10, documentation of the observed seizure activity could not be found. Additionally, a protocol for the use of the VNS (Vagus Nerve Stimulator) magnet and seizure management could not be found in the record.</p> <p>During an interview on 2/11/10 from 11:45 - 1:40 p.m., the AQMRP and LPN both stated Individual #3's seizure activity, observed on 2/8/10, should have been documented. Both the AQMRP and the LPN confirmed the seizure activity had not been documented. The LPN stated all seizure activity should be documented, and the AQMRP stated she was believed only those seizures requiring the use of the VNS magnet were to be documented.</p> <p>Additionally, when asked during the interview about a seizure and VNS protocol, the LPN</p>	W 322	Monitoring: The LPN will monitor entries into this individual's medical log at least weekly to ensure proper implementation of protocol and documentation of seizure like activity and the RN supervisor will review entries monthly as a part of the Monthly Nursing Summary review.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	Continued From page 7 provided a document from the medication administration book, undated, titled "Vagus Nerve Stimulator." The document provided general information about the VNS, and included a hand written note to swipe the magnet a second time if the seizure continued after 1 minute. However, the protocol was not individualized to indicate where Individual #3's VNS was implanted, how many times the magnet could be swiped, or how staff were to document seizure activity. Without accurate and consistent documentation, the facility would not be able to identify a change in Individual #3's seizure activity warranting and/or indicating additional medical follow up, problems with the VNS, etc., and report those changes and concerns to Individual #3's physician. The facility failed to ensure Individual #3's seizure activity was accurately and consistently documented.	W 322			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individuals' adaptive equipment was kept in good repair for 3 of 7 individuals (Individuals #3, #4, and #6) who required adaptive equipment	W 436	<u>W436</u> Corrective Actions & System Changes/Glasses: Our standard practice is for each individual to have two pairs of glasses, one they are wearing and a spare pair to be used if the primary pair is broken. If the primary pair breaks, the spare is to be used while the primary pair is repaired. To ensure this occurs, this will now be written into policy and included on the Monthly Preventative Maintenance Checklist. Corrective Actions & System Changes/Wheel Chairs: Seven of	3-10-10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

COMMUNICARE, INC #5 KUNA

STREET ADDRESS, CITY, STATE, ZIP CODE

**750 SWAN FALLS ROAD
KUNA, ID 83634**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	<p>Continued From page 8</p> <p>for mobility and vision. This resulted in individuals' adaptive equipment being in disrepair or unavailable. The findings include:</p> <p>1. Individual #3's 6/10/09 IPP stated she was a 40 year old female whose diagnoses included moderate mental retardation. Her record included a optometrist's note, dated 9/15/09, which stated she wore glasses for distance vision.</p> <p>However, during observations at the facility on 2/8/10 from 4:20 - 5:10 p.m. and 6:10 - 7:15 p.m., and on 2/9/10 from 7:10 - 8:45 a.m., Individual #3 was not observed to wear glasses. Additionally, during an observation at the facility's day program, on 2/9/10 from 10:35 a.m. - 12:10 p.m., Individual #3 was not observed to wear glasses.</p> <p>During an interview on 2/11/10 from 11:45 a.m. - 1:40 p.m., the AQMRP stated Individual #3's glasses had been broken for at least 2 weeks and a backup pair was not available. The AQMRP stated an appointment had not been set to replace the glasses, and the facility was considering changing who they obtained Individual #3's glasses from.</p> <p>The facility failed to ensure Individual #3's glasses were maintained and repaired in a timely manner.</p> <p>2. Seven of the 8 individuals residing at the facility were noted to use wheelchairs for mobility. Two of the individuals also utilized platform walkers during physical therapy. The following concerns with wheelchairs and walkers were noted:</p> <p>- During an observation at the facility's day treatment program, on 2/9/10 from 10:35 a.m. - 12:10 p.m., Individual #4's wheelchair was</p>	W 436	<p>eight individuals at this location use wheelchairs for mobility. We have implemented a wheelchair and adaptive equipment check and response system but are having both internal and external issues with this system. To ensure internal implementation, check of this system has been added to the monthly preventative maintenance checklist and the QMRP is now assigned to review this system. We have less control over external systems. The only wheelchair maintenance service now requires preauthorization before they will do any repair and this is a time consuming process. In addition, repairs and ordering of parts often takes long periods of time. The Administrator and/or RN Supervisor will continue to work with this provider in an attempt to resolve these issues and the AQMRP have been instructed to document all these issues. We will adjust our service objective to "Repair adaptive equipment" "as needed".</p> <p>Identifying Others Potentially Affected: System Changes: Seven of eight individuals at this location are potentially affected.</p> <p>Monitoring: As part of the monthly maintenance checklist, Assistant QMRPs (House Managers) will review adaptive equipment needs. This report is sent to the Administrator for review. In addition, the QMRP will review the Wheelchair Maintenance and Response System.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	Continued From page 9 observed to have a 1 inch by 1 inch rip in the right side of the padded foot rest, and two 2 inch rips on the left side of the padded foot rest. The right arm rest had a 1 inch rip in the padding, and food stains on the left side of the seat cushion. - During an environmental assessment at the facility on 2/9/10 from 1:05 - 2:20 p.m., Individual #4's platform walker was observed to have a 3 inch rip in the padding of the left arm platform, and a 4 inch rip in the padding of the right arm platform. - During an observation at the facility's day treatment program, on 2/9/10 from 10:35 a.m. - 12:10 p.m., Individual #6's wheelchair was observed to be missing the back left anti-tip bar. The left arm rest had a 6 inch broken section on the inside of the plastic frame, creating sharp edges, and was being held together with packing tape. The right arm rest had a 3 inch broken section on the inside of the plastic frame. During an interview on 2/11/10 from 11:45 a.m. - 1:40 p.m., the AQMRP stated the facility had recently changed service providers for wheelchair maintenance, causing issues with the timeliness of needed repairs. The facility failed to ensure Individual #4 and Individual #6's wheelchairs, as well as Individual #4's walker, were maintained in good repair.	W 436			
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.	W 484	W484 Corrective Actions & System Changes/Adaptive Equipment: We have provided assistance with the administration of medications in the same safe and effective manner for		4-11-10 per Sandy Preston & I via phone on 3-16-10 M. Case, LSW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 484	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all areas were equipped with eating utensils and dishes designed to meet the needs of 5 of 8 individuals (Individual #1, #2, #4, #6, and #7) residing at the facility, who required adaptive eating equipment. This resulted in individuals not being provided with adaptive eating equipment during medication administration times, or plates during snack times. The findings include: 1. An observation was conducted at the facility on 2/8/10 from 6:10 - 7:15 p.m. During that time, individuals were noted to have the following adaptive eating equipment: - Individual #7 was observed to use a cup with a built-in straw, a built-up spoon, and a divided plate with a plate guard. - Individual #4 was observed to use a cup with a built-in straw. - Individual #1 was observed to use a cup with a built-in straw. However, during an observation on 2/9/10 from 7:10 - 8:45 a.m., individuals were not observed to be provided with needed adaptive eating equipment during medication administration programs as follows: a. Individual #7 was observed to take the following liquid medications: - valproic acid syrup 240 mg/5 ml (an anticonvulsant drug) two teaspoons	W 484	many years without concerns of the nature cited in this survey being raised. The RN supervisor has reviewed these concerns and the following changes will be implemented: 1. Liquid medications will be measured into medication spoons with larger handles which we believe will facilitate maximum independence by the person receiving the medication. 2. For those people who currently use adapted cups for liquids, similar cups will be used during the SAM process. 3. We will request a review of the SAM process to determine if any further adaptations could be developed to increase each person's independence. 4. SAM programs will be updated to reflect these changes. Corrective Actions & System Changes /Adaptive Equipment during Meals: Plates will now be used during all snacks. Identifying Others Potentially Affected: All individuals at this location are potentially affected. Monitoring: The LPN, AQMRP and Lead Workers will observe the SAM's process to assure that the required adaptive equipment is used routinely. The QMRP and RN will review the observation reports monthly. Also as part of the monthly maintenance checklist process, the AQMRPs (House Managers) will review		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 484	<p>Continued From page 11</p> <p>- levetiracetam 100 mg/ml (an anticonvulsant drug) two teaspoons</p> <p>Staff were observed to pour the liquid drugs into a small paper cup and add water. The staff then provided hand-over-hand assistance for Individual #7 to drink the contents of the paper cup. Individual #7 was not offered the use of a cup with a built-in straw. The staff assisting with the medication program was noted to pause several times for Individual #7 to catch his breath. Individual #7 was observed to make a gargling sound while drinking.</p> <p>Additionally, Individual #7 was observed to take the following pills:</p> <p>- Senna Plus 8.6-50 mg (a stool softener drug) 1 tablet</p> <p>- Calcium/D 600 mg/200 iu (a dietary supplement/vitamin) 1 tablet.</p> <p>Staff were observed to crush the medications and mix them into a container of pudding. The staff then provided hand-over-hand assistance for Individual #7 to spoon the medication from the pudding to his mouth with a regular spoon. Individual #7 was not offered the use of a built-up spoon or a divided plate with a plate guard.</p> <p>b. Individual #4 was observed to swallow pills whole. Individual #4 was offered water in a paper cup. Staff provided physical assistance for Individual #4 to drink from the paper cup. Additionally, Individual #4 was observed to take polyethylene glycol 3340 (a laxative drug) 1 tablespoon mixed with 4 ounces of water. Staff provided physical assistance for Individual #4 to drink the mixture from a paper cup. A cup with a</p>	W 484	<p>adaptive equipment to assure the needed equipment is available. This report is sent to the Administrator for review.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 484	<p>Continued From page 12</p> <p>built-in straw was not offered to Individual #4.</p> <p>c. Individual #1 was observed to receive guaifenesin syrup DM (an antitussive drug) 2 teaspoons. The drug was poured into a paper cup, and the staff provided hand-over-hand assistance for Individual #1 to take the drug. The staff then offered Individual #1 water in a paper cup and provided hand-over-hand assistance for Individual #1 to drink, while using a second hand to hold Individual #1's head upright. A cup with a built-in straw was not offered to Individual #1.</p> <p>During an interview on 2/11/10 from 11:45 a.m. - 1:40 p.m., the AQMRP stated Individual #7 should have been provided with a built-up spoon during medication programming, but stated cups with built-in straws had not been considered for medication administration.</p> <p>The facility failed to ensure Individual #1, #4, and #7 were provided with adaptive eating equipment necessary to promote independence during medication administration.</p> <p>2. During an observation on 2/8/10 from 4:20 - 5:10 p.m., Individuals #2, #6, and #7 were observed to eat a snack of sliced cheese between saltine crackers. Staff were noted to assemble the crackers and cheese and provide it for individuals on pieces of paper towels. Individuals were not observed to be offered the use of plates during the snack.</p> <p>During an interview on 2/11/10 from 11:45 - 1:40 p.m., the AQMRP stated individuals' snacks should have been provided on plates rather than pieces of paper towels.</p>	W 484			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 484	Continued From page 13 The facility failed to ensure individuals were provided with plates during their snack.	W 484			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	<u>MM197</u> Please refer to W312	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an environmental assessment on 2/9/10 from 1:05 - 2:20 p.m., the following toxic chemicals were found to be unlocked: - Three bottles of ShopKo fingernail polish remover. - 41 bottles of fingernail polish. The AQMRP, who was present during the assessment, stated the fingernail polish and fingernail polish remover should have been locked. The facility failed to ensure all toxic chemicals were properly stored.	MM271	<u>MM271</u> It is our policy to keep fingernail polish and other toxic chemicals locked at all times. The fact that the locking storage closet was unlocked was a staff error. Staff will be reminded of our policy. Monitoring: the AQ and Leadworker will routinely check the door each day to further assure that the supplies are locked.	3-10-10
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such	MM380	<u>MM380</u> 1. The light outside laundry room door has been replaced.	4-11-10

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 

TITLE

 Administrator

(X6) DATE

3-10-10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 1</p> <p>character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>During an environmental assessment on 2/9/10 from 1:05 - 2:20 p.m., the following issues were noted:</p> <ul style="list-style-type: none"> - The light fixture outside the laundry room door had a broken light socket. - The drawer to the left of the dishwasher contained food debris. - The refrigerator was missing two door shelf rails and the door to the butter compartment. The door seal was ripped 8 inches around the corner and was hanging from the door. - In the power room off the main hallway, the sink was missing a 12 inch section of calking, and the light fixture by the door was not working. - In the shower room, the shower chair had a 3 inch rip through the seat cushion exposing the foam underneath. - There was a rusted can screwed to the wall in the shower room that contained pins used to 	MM380	<ol style="list-style-type: none"> Drawer to left of dishwasher has been cleaned and is cleaned regularly but is in use daily therefore occasionally food crumbs. Every effort is made to maintain the kitchen in a sanitary manor. The kitchen is routinely inspected by our RD, AQ, Lead Worker and cook. The damage to the Refrigerator had been noted prior to the survey and on the day of the survey the repairman was in the home and parts ordered. The shelves have been replaced the other repairs will be completed once the parts arrive. The caulking around the bathroom sink has been repaired and the light fixture by the door replaced. Shower chair seat is scheduled to be repaired by a local upholsterer as we have found that the supplier does not sale the "seat" separately. The shower chair pin and garbage bag containers have been removed. The missing blind slat has been replaced and the light in the outside fixture has been replaced. The corner molding to the left of furnace door has been on order and will be replaced as soon as the part arrives. 	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 2 attach arms to the shower chair, and a second rusted can on a shelf holding garbage bags. - In the bedroom shared by Individual #6 and Individual #8, the blind was missing one slat, and the light outside the exterior door was not working. - The corner molding to the left of the furnace door was missing a 4 inch section, and the door frame had a 3 inch section broken away. - The white couch in the living room had a 1 inch rip in the back right cushion, and a 12 inch by 2 inch section on the right arm was missing finish and had a 1/2 inch hole and a 2 inch rip in the fabric. - The pink recliner in the living room had a yellow stain on the left arm, a 4 inch rip on the left arm exposing the foam underneath, and a 2 inch rip on the right arm. - The front door had a 1/4 gap around the right edge. - The toilet seat in the tub bathroom was loose. The facility failed to ensure environmental repairs were maintained.	MM380	9. The white couch has been damaged by one of the residents recently. We will have it totally reupholstered. 10. The pink recliner is an electric lift type of recliner and we will have it totally reupholstered. 11. The house tends to shift with the changes of the weather. A different type of weather stripping has been installed which we hope will work better. 12. The toilet seat in tub bathroom has been tightened. Monitoring: Monthly maintenance checks are routinely completed by the A/Q. Those in turn are monitored and signed by the Administrator who will monitor progress of the needed repairs.	
MM416	16.03.11.120.05(b) Table Service Table service must be provided for all who can and will eat at a table, including residents in wheelchairs. Dining areas must be equipped with eating utensils and dishes designed to meet the developmental needs of each resident. This Rule is not met as evidenced by: Refer to W484.	MM416	<u>MM416</u> Please refer to W484	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM416	Continued From page 3	MM416			
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	<u>MM429</u> Please refer to W436		
MM575	16.03.11.210.06(a) Information in resident's record All information contained in a resident's record, including information contained in an automated data bank, will be considered confidential. This Rule is not met as evidenced by: Refer to W112.	MM575	<u>MM575</u> Please refer to W112		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	<u>MM725</u> Please refer to W159		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which	MM735	<u>MM735</u> Please refer to W322		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM735	Continued From page 4 assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735			